CENTER FOR HEALTH INFORMATION AND ANALYSIS

Data Specification Manual

957 CMR 2.00: Payer Reporting of Alternative Payment Methods

Center for Health Information and Analysis | Commonwealth of Massachusetts

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Introduction

M.G.L. c. 12C, § 10 requires the Center for Health Information and Analysis ("Center") to collect from private and public health care payers "data on changes in type of payment methods implemented by payers and the number of members covered by alternative payment methodologies" and "the average negotiated monthly or yearly budget weighted by member months for each geographic region of the commonwealth." M.G.L. c. 12C, § 16 further directs the Center to collect "the proportion of health care expenditures reimbursed under fee-for-service and alternative payment methodologies."

Regulation 957 CMR 2.00 governs the methodology and filing requirements for health care payers to report this data to the Center. The Data Specification Manual provides additional technical details to assist payers in reporting and filing this data.

Payers are required to submit one Alternative Payment Methods (APM) file to the Center annually. The file will contain payment method data for the previous calendar year. Files can only contain data for one year. Files will contain different record types, including:

a. Payer Comments
b. Separate alternative payment methods data with distinct lines for Medicare Advantage, Medicaid Managed Care, Commonwealth Care, and commercial by:
    - Registered Provider Organization
    - Zip Code

File Submission Instructions and Schedule

Payers will submit Excel files with alternative payment data by locking the Excel files, and emailing the files to tmerp@state.ma.us. Payers will then send a separate email with the Password to unlock their Excel files to the same email address.

Payers will submit alternative payment methods data in accordance with regulation 957 CMR 2.00 on the following schedule:

Alternative Payment Methods Filing Schedule	
Date	**File Due**
May 15, 2013	CY 2012 Alternative Payment Methods

Data Submission

For the reporting of claims payments, payers shall report the allowed dollar amounts, i.e. provider payment and any patient cost-sharing amount. Payers shall exclude any paid claims for which it was the secondary or tertiary payer.

Payers shall allocate non-claims payments by member months for zip-code level reporting.

For both provider level and zip code level reporting, payers must report data for all Massachusetts residents based on zip code of residence as of the last day of the reported year, December 31st, or the last day in the payer's network. For the assignment of payment methods, payers shall allocate the

payment method and payment amount by member month and follow the allocation logic shown in Appendix A.

Payers must report the APM data assuming a neutral health status adjustment score of 1.0 using an industry accepted health status adjustment tool.

Payers shall classify payment methods for each provider organization based on the member's associated payment method. Even though most alternative payment methods are layered on a fee-for-service structure, the overall settlement process at the end of the cycle determines the payment arrangement type for all of those dollars paid under the specific contract. For example, if a member is under a global payment contract, the dollar amount associated with this member should be classified as a global payment method even though the payer utilizes a fee-for-service payment mechanism to reimburse providers at the transactional level. The same logic applies to limited budget or bundled payment arrangements. The dollar amount reported for limited budget or bundled payment arrangements shall include all dollar amounts paid for the members associated with the contract, even if a fee-for-service mechanism was used for claims processing and payment transaction purposes.

Provider Level Reporting

For registered provider organizations, payers must report data for all organizations that have registered with the Health Policy Commission. For calendar year 2013 reporting of the calendar year 2012 data, payers may use contracting entity IDs to best mimic how they will report physician groups once registered with the Health Policy Commission. Payers shall report contracting entities that have at least 36,000 Massachusetts member months attributed to them. Payers must report separate lines for the affiliated parent physician groups underneath the contracting entity if the parent physician group has more than 36,000 member months. Payers must report separate lines for the affiliated local practice groups underneath the parent physician groups and contracting entity if the local practice group has greater than 36,000 member months. If the contracting entity's affiliated parent physician groups and local practice groups do not individually meet the 36,000 member month threshold, then payers must report the data in aggregate using OrgID 999997 in the parent physician group and local practice group OrgID fields.

Payers shall only report data for Massachusetts residents, based on the member's zip code as of the last day of the reporting year, December 31st. Payers shall report APM data by registered provider organizations for those members whom the payer is able to attribute to a provider organization. If the payer uses an attribution model for product types that do not require the member to select a primary care physician, then the payer should include those members in the respective provider organization.

If the payer holds more than one contract type with a registered provider organization, then the payer must separately report the APM data by each type of contract.

Zip - Code Level Reporting

For zip-code level data, payers must report alternative payment methods data by zip code for all Massachusetts members based on the zip code of the member, as of the last day of the reporting period. The Center shall not publicly report zip code APM data unless aggregated to an amount appropriate to protect patient confidentiality.

Field Definitions: Provider Level

Registered Provider Organization ID (CY 2012 data - Contracting Entity ID): The ID assigned by the Health Policy Commission for the Registered Provider Organization. For CY 2012 data, payers may submit their own contracting entity ID for each organizational entity with whom it contracts. A Contracting Entity is defined as "the provider who holds a contract with the payer and is paid for services in accordance with a payment model based on a prospectively or retrospectively defined budget."

Physician Group OrgID: The OrgID assigned by the Center for the Physician Parent Group. Refer to Appendix B for the number associated with the Physician Parent Group.

Local Practice Group OrgID: The OrgID assigned by the Center for the Local Practice Group. Refer to Appendix B for the number associated with the Local Practice Group.

Insurance Category Code: A number that indicates the reported insurance category.

Insurance Category Code	Definition
1	Medicare & Medicare Advantage
2	Medicaid & Medicaid MCO
3	Commonwealth Care
4	Commercial
5	Other (MSP, SCO, PACE, Bridge)

Product Type: The product type under the insurance category reported.

Product Type Code	Definition
1	HMO and POS
2	PPO
3	Indemnity
4	Other

Payment Method: Payments will be reported by payment method, as defined below.

Global Budget/Payment: Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a comprehensive set of services for a broadly defined population. Contract must include at a minimum: physician services and inpatient and outpatient hospital services.

Examples include shared savings and full/partial risk arrangements. The global budget/payment method should be separated into two categories: (1) Global Budget/Payment Full Benefits and (2) Global Budget/Payment Partial Benefits. Global Budget/Payment Full Benefits contains the budget and payment data for a comprehensive set of services. Global Budget/Payment Partial Benefits contains the budget and payment data for a defined set of services, where certain benefits such as behavioral health services or prescription drugs are carved out and not part of the budget. If you are reporting a physician group contract that has a carve-out service, then you would report that line twice, once as 1A with the full dollar amount, including carve-out payments, and then again as 1B with the carve-out payments excluded. The data line for payment method 1B will be a subset of the data line for payment method 1A.

Limited Budget: Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a non-comprehensive set of services to be delivered by a single provider organization (such as capitated primary care and oncology services).

Bundled Payments: Fixed dollar payments for the care that patients may receive in a given episode of care for a specific condition delivered by multiple provider types.

Other, non-FFS based: All other payment arrangements not based on a fee-for-service model, including supplemental payments for the Patient Center Medical Home Initiative (PCHMI).

Fee for Service (FFS): A payment mechanism in which all reimbursable health care activity is described and categorized into discreet and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient. Fee for service payment includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs)), claims-based payments adjusted by performance measures, and discounted charges-based payments. This category also includes Pay for Performance incentives that accompany FFS payments.

Payment Method Code	Definition
1A	**Global Budget/Payment (Full Benefits: budget includes comprehensive services)**
1B	**Global Budget/Payment (Partial Benefits: certain services carved-out and not part of the budget)**
2	**Limited Budget**
3	**Bundled Payments**
4	**Other, non-FFS based**
5	**Fee for Service**

Member Months: The number of members participating in a plan over the specified period of time expressed in months of membership.

Health Status Adjustment Score: A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors.

Average Monthly Budget: The total budgeted amount divided by the number of member months under a given contract. If the contracted budget does not align with the calendar year, annualize the budget by the appropriate member months. If the average monthly budget is not set in the contract, then calculate the amount by dividing the total spending associated with the member under the contract by the member months. Please note that this field only applies to global and limited budget payment arrangements.

Total Claims Payments: The sum of all associated claims payments, including patient cost sharing amounts, for each insurance category, product type, and payment method combination.

Total Non-Claims Payments: The sum of all associated non-claims payments for each insurance category, product type, and payment method combination.

Total Payments: The sum of Total Claims Payments and Total Non-Claims Payments.

Amount of Total Payments due to Financial Performance Measures: The subset dollar amount of the total payments paid for financial performance-based contracts for each insurance category, product type, and payment method combination. A financial performance payment is defined as additions to the base payment or adjustments to a contracted payment amount made based solely on the achievement of financial or cost-based measures.

Amount of Total Payments due to Quality Performance Measures: The subset dollar amount of the total payments paid for quality performance-based contracts, for each insurance category, product type and payment method combination. A quality performance payment is made either as an addition to the base payment or as an adjustment to a contracted payment amount, in both cases to reward a provider for quality, access and/or patient experience. Quality performance-based contracts do not include contracts that incorporate payment adjustments based solely on provider cost or efficiency performance.

Amount of Total Payments due to Financial and Quality Performance Measures Combined: The subset dollar amount of the total payments paid for combined financial and quality performance-based contracts, for each insurance category, product type and payment method combination. These include contracts that incorporate payment adjustments based on linked financial and quality performance measures.

Field Definitions: Zip Code Level

Zip Code: Five digit Massachusetts zip-code to which members are attributed. Select from roster in Appendix C.

Insurance Category Code: A number that indicates the reported insurance category.

Insurance Category Code	Definition
1	Medicare & Medicare Advantage
2	Medicaid & Medicaid MCO
3	Commonwealth Care
4	Commercial
5	Other (MSP, SCO, PACE, Bridge)

Product Type: The product type under the insurance category reported.

Product Type Code	Definition
1	HMO and POS
2	PPO
3	Indemnity
4	Other

Payment Method: Payments will be reported by payment method, as defined below.

Global Budget/Payment: Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a comprehensive set of services for a broadly defined population.

Contract must include at a minimum: physician services and inpatient and outpatient hospital services. Examples include shared savings and full/partial risk arrangements. The global budget/payment method should be separated into two categories: (1) Global Budget/Payment Full Benefits and (2) Global Budget/Payment Partial Benefits. Global Budget/Payment Full Benefits contains the budget and payment data for a comprehensive set of services. Global Budget/Payment Partial Benefits contains the budget and payment data for a defined set of services, where certain benefits such as behavioral health services or prescription drugs are carved out and not part of the budget. If you are reporting a physician group contract that has a carve-out service, then you would report that line twice, once as 1A with the full dollar amount, including carve-out payments, and then again as 1B with the carve-out payments excluded. The data line for payment method 1B will be a subset of the data line for payment method 1A.

Limited Budget: Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a non-comprehensive set of services to be delivered by a single provider organization (such as capitated primary care and oncology services).

Bundled Payments: Fixed dollar payments for the care that patients may receive in a given episode of care for a specific condition delivered by multiple provider types.

Other, non-FFS based: All other payment arrangements not based on a fee-for-service model, including supplemental payments for the Patient Center Medical Home Initiative (PCHMI).

Fee for Service (FFS): A payment mechanism in which all reimbursable health care activity is described and categorized into discreet and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient. Fee for service payment includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs)), claims-based payments adjusted by performance measures, and discounted charges-based payments. This category also includes Pay for Performance incentives that accompany FFS payments.

Payment Method Code	Definition
1A	**Global Budget/Payment (Full Benefits: budget includes comprehensive services)**
1B	**Global Budget/Payment (Partial Benefits: certain services carved-out and not part of the budget)**
2	**Limited Budget**
3	**Bundled Payments**
4	**Other, non-FFS based**
5	**Fee for Service**

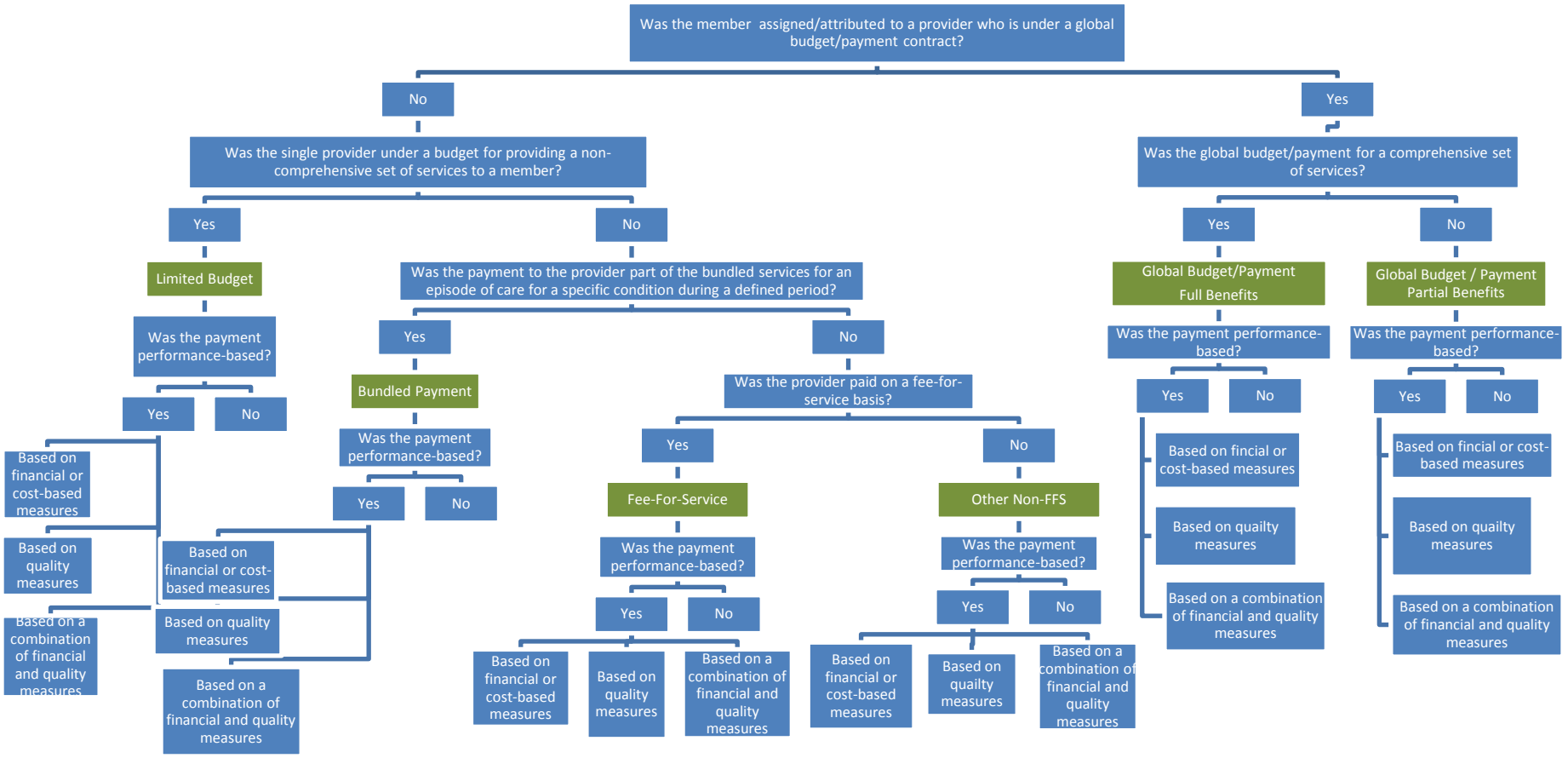
Member Months: The number of members participating in a plan over the specified period of time expressed in months of membership.

Health Status Adjustment Score: A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors.

Total Payments: The sum of all associated payments for each insurance category, product type, and payment method combination. This includes both provider claims and non-claims payments and any patient cost sharing amounts.

For detailed information on data submission, please see Appendix D.

Appendix A: Payment Method Allocation Logic



Appendix B. Physician Group OrgIDs

Please visit:

http://www.mass.gov/chia/researcher/health-care-delivery/hcf-data-resources/payer-data-reporting/

Appendix C. Massachusetts Zip Codes

Please visit:

http://www.mass.gov/chia/researcher/health-care-delivery/hcf-data-resources/payer-data-reporting/

Appendix D: Data Submission Guidelines

Record Type	Column	Element	Data Element Name	Type	Format	Length	Element Submission Guideline
HD	1	HD001	Payer ID	Integer	######	6	Payer's Submission OrgID as defined by the Center.
HD	2	HD002	Calendar Year	Date	YYYY	4	The calendar year of the data being submitted
HD	3	HD003	Provider Record Count	Integer	######	6	Record Count for Provider-level data
HD	4	HD004	Zip-Code Record Count	Integer	######	6	Record Count for Zip-Code level data
HD	5	HD005	Health Status Adjustment Tool Name and Version	Text	Text	100	The name and version of the software used for the Health Status Adjustment Tool.
PL	1	PL001	Registered Provider Organization ID	Integer	######	6	Registered Provider Organization ID assigned by the Health Policy Commission. For CY 2012 data, this field will be the payer's assigned ID for the Contracting Entity (payer defined entity based on contracting structure). **Please see Field Definitions: Provider Level for more detail.**
PL	2	PL002	Physician Parent Group OrgID	Integer	######	6	OrgID assigned by the Center for each physician group. **Please see Appendix B.**
PL	3	PL003	Local Practice Group OrgID	Integer	######	6	OrgID assigned by the Center for each physician group. **Please see Appendix B.**
PL	4	PL004	Insurance Category Code	Integer	#	1	Insurance Category **Please see Table A (Insurance Category)**
PL	5	PL005	Product Type	Integer	#	1	Product Type **Please see Table B (Product Type)**

PL	6	PL006	Payment Method	Integer	#	1	Assigned payment method. Please see Appendix A for more details. **Please see Table C (PaymentMethod)**
PL	7	PL007	Member Months	Integer	#########	9	The number of members participating in a plan over a specified period of time expressed in months of membership.
PL	8	PL008	Health Status Adjustment Score	Number	##.##	6	A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors.
PL	9	PL009	Average Monthly Budget Per Member	Money	########.##	12	The total budgeted amount divided by the number of member months under a given contract. **Please see Field Definitions: Provider Level for more detail.**
PL	10	PL010	Total Claims Payments	Money	########.##	12	The sum of all associated medical claims payments for each insurance category, product type, and payment method combination. This includes both provider payments and any patient cost sharing amounts.
PL	11	PL011	Total Non-Claims Payments	Money	########.##	12	The sum of all associated non-claims payments for each insurance category, product type, and payment method combination.
PL	12	PL012	Total Payments	Money	########.##	12	The sum of Total Claims Payments and Total Non-Claims Payments.
PL	13	PL013	Amount of Total Payments due to Financial Performance Measures	Money	########.##	12	The subset dollar amount of the total payments paid for financial performance-based contracts for each insurance category, product type, and payment method combination. **Please see Field Definitions: Provider Level for more detail.**
PL	14	PL014	Amount of Total Payments due to Quality Performance	Money	########.##	12	The subset dollar amount of the total payments paid for quality performance-based contracts, for each insurance category, product type and payment method combination.

			Measures				**Please see Field Definitions: Provider Level for more detail.**
PL	15	PL015	Amount of Total Payments due to Financial and Quality Performance Measures Combined	Money	######### ###.##	12	The subset dollar amount of the total payments paid for combined financial and quality performance-based contracts, for each insurance category, product type and payment method combination. **Please see Field Definitions: Provider Level for more detail.**
ZL	1	ZL001	Zip Code	Integer	#####	5	Massachusetts zip code **Please see Appendix C.**
ZL	2	ZL002	Insurance Category Code	Integer	#	1	Insurance Category **Please see Table A (Insurance Category)**
ZL	3	ZL003	Product Type	Integer	#	1	Product Type **Please see Table B (Product Type)**
ZL	4	ZL004	Payment Method	Integer	#	1	Assigned payment method. Please see Appendix A for more details. **Please see Table C (Payment Method)**
ZL	5	ZL005	Member Months	Integer	#########	9	The number of members participating in a plan over a specified period of time expressed in months of membership.
ZL	6	ZL006	Health Status Adjustment Score	Number	##.##	6	A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors.
ZL	7	ZL007	Total Payments	Money	######### ###.##	12	The sum of all Claims and Non-Claims Payments.

Table A. Insurance Category

ID	Description
1	Medicare and Medicare Advantage
2	Medicaid and Medicaid MCO
3	Commonwealth Care
4	Commercial
5	Other (MSP, SCO, PACE, Bridge)

Table B. Product Type

ID	Description
1	HMO and POS
2	PPO
3	Indemnity
4	Other (e.g. EPO)

Table C. Payment Method

ID	Description
1A	Global Budget/Payment (Full Benefits: budget includes comprehensive services)
1B	Global Budget/Payment (Partial Benefits: certain services carved-out and not part of the budget)
2	Limited Budget
3	Bundled Payments
4	Other, non-FFS based (e.g. PCMHI)
5	Fee For Service